The President's Emergency Plan for AIDS Relief Indicators, Reporting Requirements, and Guidelines

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Contents

INTRODUCTION

Strategic information is a cornerstone of the scientific basis of The President's Emergency Plan for AIDS Relief (The Emergency Plan). With aggressive five-year goals of treating more than 2 million HIV-infected persons with effective combination antiretroviral therapy, preventing 7 million new HIV infections, and caring for 10 million HIV-infected persons and those orphaned by HIV/AIDS, it is imperative that the priority countries have well-developed and timely data from surveillance and program monitoring, each supported by appropriate health management information systems (HMIS) and other information technology.

Strategic information serves multiple purposes: to assist countries in planning and monitoring services, and to provide information to the United States Government (USG) for The Emergency Plan reporting and for the international donor community. The two broad types of information required to monitor performance of The Emergency Plan implementation in host countries include:

1. A limited set of program monitoring indicators to track key USG-supported activities
2. National outcome and impact indicators that measure joint progress with other international donors through a variety of methods

The purpose of this document is to provide guidance regarding data collection and reporting for The Emergency Plan program monitoring and evaluation, including outputs, outcomes and impacts. There are four sections:

1. Table 1, which shows the required program-level data reporting elements
2. Table 2, which shows how the data collected relates to the goals of The Emergency Plan
3. The program-level monitoring matrices, which further describe and define the program-level data in Table 1
4. The outcome and impact level indicators with their data collection methods and international standard sources, separated into core and recommended indicators

Table 1: The Emergency Plan Program-level Reporting Framework

There is one semiannual USG report per country due every six months to United States Department of State/ Office of the Global AIDS Coordinator (S/GAC). The first report, for the period April 1, 2004, through September 30, 2004, is due on October 31, 2004. The core program monitoring indicators of The Emergency Plan are collected from program data/reports, routine facility-based HMIS, and logistical MIS.

Table 1 shows the framework developed for monitoring of program progress in the field. Field offices are responsible for providing S/GAC with all designated data in this table (shown with x's, asterisks, and crosses). Please become very familiar with this table and ensure that the field staff fully understands what each symbol is requesting.

The program-level data required vary by service category. Generally, within each program area (corresponding roughly to expected budget categories), program expansion will be tracked with indicators representing:

1. Number of service outlets/programs
2. Number of clients served
3. Number of health workers trained in the service

Additionally, some categories ask for the sums from the different programs or subsets of different totals. Please see 'Additional Important Information' below for more details.

One should avoid double-counting the same individual within one service/program area during each reporting period. Thus, if one orphan or vulnerable child (OVC) is receiving school-related expenses from a program and also receives periodic nutritional support and counseling, this child is only counted once within the reporting period. We rely on the USG agencies and programs to ensure that while program-level summary counts only count the number of persons served once, each person served should be given the appropriate quality package of services, according to national/international standards.

It is acceptable to count the same person in multiple service/program areas (e.g., OVC and prevention of mother-to-child prevention plus (PMTCT+), antiretroviral therapy (ART) and Palliative Care) but not to count a person for the same service multiple times. Persons receiving services in multiple reporting cycles, however, will be counted again in the next cycle if they are still receiving services (e.g., a person on ART served in one six-month period will also be counted if he/she is served in the next reporting period). Thus, your report shows the total number of persons currently being served within each reporting period.

The same applies to counting numbers of people trained. A person trained more than once within a given period is only counted as one person trained; however, if this person is trained in a different area then he/she can also be counted for that area. In the Totals boxes, the USG office is asked to try to give, to the best of its ability, the total number of persons trained in all areas without duplication. We realized that different program monitoring systems may not be not well linked; the intention, however, is for this number to represent unduplicated numbers within the broader programmatic area: Prevention, PMTCT, Counseling and Testing, Treatment, Palliative Care, OVC, etc.

The indicators presented here are the minimum program-level reporting requirements under The Emergency Plan. However, they represent a subset of what programs need to be monitoring to manage and improve their programs locally. A good example of additional information that would be desirable is geographical coverage of service sites. Age of clients served is another useful variable that is not required in the aggregate counts due to S/GAC, but that would be useful to program managers at the national level.

Table 2: The Emergency Plan Goals

Table 2 shows how specific information from Table 1 will be used to measure The Emergency Plan's overall goals of reaching two million people with ART, preventing seven million infections, and providing care and support for 10 million HIV-infected individuals and orphans and vulnerable children. For example, the number of people receiving ART will be measured by adding 'Number of clients served' under 'Treatment: ART' and 'Number of clients served' under 'Treatment: PMTCT+.'

Program-level Reporting Matrices

In the program-level monitoring matrices, each indicator is further described. The definition of the category is given and then definitions for each of the indicators in that category. More general definitions are below.

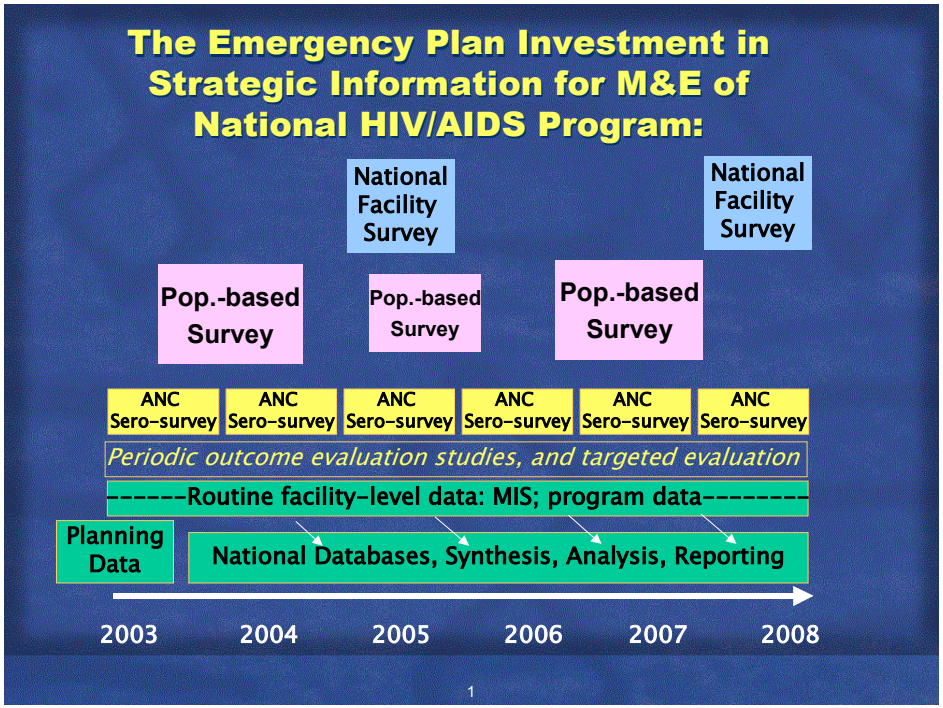
Core Emergency Plan Outcome- and Impact-level Indicators Summary Table

This table shows the national outcome and impact indicators that S/GAC will use to measure national-level achievements. Please note that these core national-level outcome and impact indicators are measured with data sources including population-based surveys, targeted facility surveys, sentinel surveillance systems or sero-surveys, and cohort studies.

Baseline data for these core indicators should be collected by the end of fiscal year 2004 or mid-fiscal year 2005. Existing data from 2002 and 2003 are acceptable as a baseline. Surveillance information should be collected yearly or every other year; national population and health facility surveys every 2 to 3 years. Special studies may be desired in order to supplement existing data to address programmatic needs and to document successful models.

The core Emergency Plan outcome and impact indicators are designed for generalized epidemics in Emergency Plan focus countries only. There will be a need to tailor indicators to high-risk groups to be tracked in specific settings through targeted behavioral surveillance or second generation surveillance, as The Emergency Plans extends to funding more work in countries with concentrated epidemics.

The figure below illustrates the proposed timing for the various methodologies necessary to collect all core strategic information data for The Emergency Plan.



Core Emergency Plan Outcome- and Impact-level Indicators Definitions

These indicators and their definitions are drawn from and align with international standards and measurement tools wherever possible and provide evidence of trends related to behavior change, health infrastructure capacity and quality, care and support, and impact of care and treatment, including morbidity and mortality.

Recommended Emergency Plan Outcome- and Impact-level Indicators Summary Table

Among the indicators that are recommended under The Emergency Plan at this point some are appropriate at the sub-national level only, thus their exclusion from the core set of The Emergency Plan indicators. Some of the indicators have methodologies that are still under development. The Recommended Emergency Plan Outcome- and Impact-level Indicators Summary Table indicates this, as well as the group leading the piloting or testing of the methodology.

Additional Important Information

Definitions

- **Service outlets/programs** = USG-supported (see below). A service outlet refers to *the lowest level of service*. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit. For programs such as prevention efforts implemented through mass media or community outreach, the level at which the program is counted is the level at which funds are obligated. For example, a national mass media program is counted only once. However, if the USG is independently funding mass media programs at the provincial level, each province's program should be counted. Both terms (service outlet/programs) are used to account for the different formats through which activities are delivered, i.e., prevention programs and health care service outlets.
- **Clients served** = count of people receiving services, disaggregated by sex.
- **Trained** = count of persons trained in a particular programmatic area. Training refers to new training or retraining of individuals and assumes that training is conducted according to national or international standards when these exist.
- **USG-supported** = any HIV service outlet/program that receives at least some of its funding or support from the USG. It is likely that country service outlets/programs will be supported by a mixture of funds from varied sources, including the USG. Because we cannot separate USG clients from other clients in an USG-funded service or program, all clients of an USG supported service or program should be counted toward USG prevention, care, and treatment goals. In multi-service/program institutions, please count clients for the service or program component that is being funded. For example, if the USG is contributing funds to support a PMTCT clinic in a large hospital, all clients in that PMTCT clinic should be counted as USG clients, regardless of other funding received by the clinic. However, if the hospital is providing ARVs in another clinic that does not receive USG funds, clients in that clinic should ***not*** be counted as part of an USG-supported program. If, for example, a program receives USG funding for PMTCT and Global Fund funding for Counseling and Testing, only the PMTCT clients will be reported and the service outlet is counted under PMTCT. However, if the program receives both USG and Global Fund funding for PMTCT, it is acceptable to report all clients served in PMTCT, as it would be very difficult to divide the clients served in some way.
- **Abstinence only**= Activities or programs that ***only*** promote the:
  1. Importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals;
  2. Decision of unmarried individuals to delay sexual activity until marriage;
  3. Development of skills in unmarried individuals for practicing abstinence; and
  4. Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals
- **Abstinence and faithfulness**= Activities or programs that promote **a**bstinence combined with the:
  1. Importance of faithfulness in reducing the transmission of HIV among individuals in long-term sexual partnerships;
  2. Elimination of casual sex and multiple sexual partnerships;
  3. Development of skills for sustaining marital fidelity;

4. Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and
5. Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships

Understanding Table 1

The program-level data required for reporting vary by category. As an example, under Prevention, the total number of faith-based service outlets and/or programs is a reporting requirement. This number will be a subset of the total number of Prevention service outlets/programs. It is not required to report the number of faith-based facilities under each Prevention activity—behavior change, medical transmission, and STI management. Regardless, it is necessary to know which prevention programs are conducted by faith-based service outlets so that this total can be reported to S/GAC.

Subsets

Several indicators are subsets of other indicators. In Table 1, columns two, three, and four are subsets of column one; columns six and seven are subsets of column five. For example, it could be reported that there are 100 prevention service outlets/programs and *of those*, 20 are faith-based, or that there are 100 ART clients and *of those,* 20 are new. Additionally, ARV prophylaxis within PMTCT is a subset of the total number of clients served in PMTCT.

Commodities

Commodities such as drugs (ARVs and OI drugs), HIV test kits, and condoms will be tracked in a separate procurement/commodities database.

Table 1: The Emergency Plan Program-Level Reporting Framework

Program/Service Area	Number of service outlets/ programs	*Number of faith-based service outlets/ programs*[1]	*Number of abstinence and faithfulness-focused programs*[2]	*Number of abstinence only programs*[3]	Number of clients served	*Number of new clients served*[4]	*Number of current clients in continuous services for more than 12 months*[5]	Number of people trained
Prevention	x (total)	x (total)						x (total)
Behavior Change								
Community Outreach	x		x	x	*			x
Mass Media	x		x	x	x[6]			x
Medical Transmission								
Blood safety	x							x
Injection safety					.			x
STI Management	x				*			x
PMTCT	x (total)	x (total)			x (total)			x (total)
ARV prophylaxis within PMTCT[7]					x			
Counseling and Testing	x (total)	x (total)			* (total)			x (total)
Treatment (ART)	x (total)	x (total)			* (total)			x (total)
ART	x				*†	*†	*†	x
PMTCT+	x				*†	*†	*†	x
Palliative Care (non-ART care)	x (total)	x (total)			* (total)			x (total)
Basic Health Care and Support (excluding TB/HIV)	x, x[m8]				*			x
TB/HIV	x				*			x
OVC	x	x			*			x
Labs	x							x
Strategic Information								x
Other: Policy and Systems Strengthening (Capacity Building)	x	x						x

*Number of clients to be collected, disaggregated by sex
† Number of clients to be collected, disaggregated by pregnancy status

[1] Number of faith-based service outlets/programs is a subset of the number of service outlets/programs.
[2] Number of abstinence and faithfulness-focused programs is a subset of the number of programs.
[3] Number of abstinence only programs is a subset of the number of programs.
[4] Number of new clients is a subset of number of clients.
[5] Number of clients in continuous service is a subset of number of clients.
[6] Mass media programs will need to estimate program coverage of clients served.
[7] Number of PMTCT clients receiving ARV prophylaxis is a subset of the total number of PMTCT clients.
[8] Number of all Basic Health Care and Support (excluding TB/HIV) service outlets/programs providing malaria care and/or referral; this is a subset of the number of all Basic Health Care and Support service outlets/programs

Table 2: The Emergency Plan Goals

Progress To Goals	Service Categories			
	Prevention	Treatment	Care and Support	
		ART and PMTCT+	Palliative Care	OVC
Total number of clients reached with ART (goal: 2 million)		x		
Total number of new infections prevented (goal: 7 million)	modeled			
Total number of clients reached with care and support (goal: 10 million)			x	x

This table shows how specific information from Table 1 will be used to measure The Emergency Plan overall goals of reaching 2 million people with ART, preventing 7 million infections, and providing care and support for 10 million HIV-infected individuals and orphans and vulnerable children. For example, the number of people receiving ART will be measured by adding the 'Number of clients served' under 'Treatment: ART' and 'Treatment: PMTCT+.'

In order to reach the goal of delivering ART to 2 million people, The Emergency Plan will count the existing number of cases on ART or PMTCT+ and will add new cases each reporting period. The goal of averting 7 million infections will be modeled by The Emergency Plan using data from the prevention service area counts. Finally, the 10 million reached with Care and Support will be calculated using the records from Palliative Care and OVC from Table 1.

It is assumed that nearly 100% of all clients on treatment, through an ART or a PMTCT+ program, are also receiving palliative care services. This assumption implies that some number of the total number of clients receiving palliative care will be the same individuals as the total number of clients receiving treatment.

If an HIV+ OVC is receiving treatment as well as care in an OVC program, the OVC should be counted both under treatment ***and*** under OVC. However, an HIV+ OVC receiving palliative care services among other services within an OVC program should ***only*** be counted under OVC to avoid double counting under the total care count.

PROGRAM-LEVEL MONITORING MATRICES

Totals of Prevention Services/Programs

Definition: Total of all programs, services, and activities aimed at preventing the transmission of HIV, i.e., behavior change (mass media and community outreach), medical transmission (blood safety and injection safety), and/or sexually transmitted infection (STI) management service outlets/programs. See individual prevention service and program areas for definitions of each of these.

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlets/programs	Total number of service outlets/programs providing prevention services, i.e., the total of the number of behavior change (mass media and community outreach), medical transmission (blood safety and injection safety), and STI management service outlets/programs.	Program reports
Number of faith-based service outlets/programs	Total number of faith-based service outlets/programs providing prevention services. This will be the total of the number of faith-based, behavior change (mass media and community outreach), medical transmission (blood safety and injection safety), and STI management service outlets/programs. This is a subset of the total number of prevention service outlets/programs.	Program reports
Number of persons trained	Total number of persons trained to provide prevention services, i.e., the total of the number of persons trained in behavior change (mass media and community outreach), medical transmission (blood safety and injection safety), and STI management.	Program reports

Behavior Change: Community Outreach

Definition: Community outreach behavior change activities outside of mass media, medical transmission, and STI management, aimed at preventing HIV transmission. Could include community mobilization, peer education, classroom, small group and/or one-on-one information, education, and communication (IEC) and behavior change communication (BCC) messages/programs to promote avoidance of or reduction of HIV risk behaviors, and the social marketing and/or promotion of condoms. This includes work with high-risk group such as intravenous drug users (IDUs), men who have sex with men (MSM), commercial sex workers (CSWs), and people living with HIV and/or AIDS (PLWHA), as well as activities (including training) to promote abstinence until marriage, delay of first sex, faithfulness, partner-reduction, and related social and community norms.

Indicator type	**Indicator**	**Source/ Methodology**
Number of programs	Number of programs providing community outreach HIV behavior change services. *Note: Though the number of faith-based behavior change/community outreach programs is not required to be reported, these data will need to be collected so that total number of faith-based prevention programs can be reported.*	Program reports
Number of abstinence and faithfulness-focused programs	Number of programs providing community outreach HIV behavior change services that include an abstinence and faithfulness messages. This is a subset of the total number of community outreach HIV behavior change programs.	Program reports
Number of abstinence only programs	Number of programs providing community outreach HIV behavior change services that include an abstinence only message. This is a subset of the total number of community outreach HIV behavior change programs.	Program reports
Number of clients served	Number of individuals served by programs providing community outreach HIV behavior change services, disaggregated by sex.	Program reports
Number of persons trained	Number of persons trained to provide community outreach HIV behavior change services.	Program reports

Notes:

1. Number of condoms to be tracked in separate procurement/commodities database.
2. As The Emergency Plan expands into concentrated epidemic countries, specific high-risk group indicators looking at groups such as IDUs, CSWs, and MSM will become necessary.

Behavior Change: Mass Media

Definition: Mass media behavior change activities outside of community outreach, medical transmission, and STI management, aimed at preventing HIV transmission. Could include national and/or sub-national programs that involve radio and/or television addresses, and/or any other mass-scale dissemination of IEC and BCC messages to promote avoidance of or reduction of HIV risk behaviors, and the social marketing and/or promotion of condoms. This includes work with high-risk group such as IDUs, MSM, CSWs, and PLWHA, as well as activities (including training) to promote abstinence until marriage, delay of first sex, faithfulness, partner-reduction and related social and community norms.

Indicator type	**Indicator**	**Source/ Methodology**
Number of programs	Number of programs providing mass media HIV behavior change services. *Note: Though the number of faith-based behavior change/mass media service outlets/programs is not required to be reported, these data will need to be collected so that total number of faith-based prevention programs can be reported.*	Program reports
Number of abstinence and faithfulness-focused programs	Number of programs providing mass media HIV behavior change services that include an abstinence and faithfulness messages. This is a subset of the total number of mass media HIV behavior change programs.	Program reports
Number of abstinence only programs	Number of programs providing mass media HIV behavior change services that include an abstinence only message. This is a subset of the total number of mass media HIV behavior change programs.	Program reports
Number of clients served	Number of individuals served by programs providing mass media HIV behavior change services.[9]	Program coverage estimates
Number of persons trained	Number of persons trained to provide mass media HIV behavior change services.	Program reports

[9] This number is derived from program coverage estimates of clients served.

Medical Transmission: Blood Safety

Definition: Activities supporting a national coordinated blood program, which includes policies; infrastructure, equipment and supplies; donor recruitment activities; blood collection, distribution/supply chain/logistics, testing, screening, and transfusion; waste management; training; and management to ensure a safe and adequate blood supply.

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlets/programs	Number of service outlets/programs carrying out blood safety activities. *Note: Though the number of faith-based blood safety service outlets/programs is not required to be reported, these data will need to be collected so that total number of faith-based prevention programs can be reported.*	Program reports
Number of persons trained	Number of persons trained in blood safety.	Program reports

Medical Transmission: Injection Safety

Definition: Policies, training, waste management systems, advocacy, and other activities to promote (medical) injection safety, including distribution/supply chain/logistics, cost, and appropriate disposal of injection equipment, and other related equipment and supplies.

Indicator type	Indicator	Source/ Methodology
Number of persons trained	Number of persons trained in injection safety.	Program reports

Notes:

1. Number of single-use syringes to be tracked in a separate procurement/commodities database.

STI Management

Definition: sexually transmitted infection management services outside of designated HIV care and treatment programs (i.e., if not in palliative care or ART settings).

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlets	Number of service outlets providing STI management services according to national or international standards. *Note: Though the number of faith-based STI management service outlets/programs is not required to be reported, these data will need to be collected so that total number of faith-based prevention programs can be reported.*	Program reports
Number of clients served	Number of individuals provided with STI management services, disaggregated by sex.	Program reports/HMIS
Number of persons trained	Number of persons trained to provide STI management services according to national or international standards.	Program reports

Totals for Prevention of Mother-to-Child Transmission Services

Definition: Activities aimed at providing the minimum package of services for preventing mother-to-child transmission including:

A. counseling and testing for pregnant women
B. ARV prophylaxis to prevent MTCT
C. counseling and support for safe infant feeding practices
D. family planning counseling or referral

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlets	Total number of service outlets providing the minimum package of PMTCT services according to national or international standards.	Program reports
Number of faith-based service outlets	Total number of faith-based service outlets providing the minimum package of PMTCT services according to national or international standards. This is a subset of the total number of service outlets providing PMTCT services.	Program reports
Number of clients served	Total number of pregnant women receiving PMTCT services.	Program reports/HMIS
Number of clients receiving ARV prophylaxis	Total number of pregnant women receiving a complete course of antiretroviral prophylaxis in a PMTCT setting. This is a subset of the total number of pregnant women receiving PMTCT services.	Program reports/HMIS
Number of persons trained	Total number of health workers newly trained or retrained in the provision of PMTCT services according to national or international standards.	Program reports

Notes:

1. PMTCT+ activities are a separate category.
2. By definition, any pregnant woman who received PMTCT services also received counseling and testing.

Totals for HIV Counseling and Testing Services

Definition: Activities in which both HIV counseling and testing are provided for those who want to know their HIV status (as in traditional VCT) or as indicated in other contexts (e.g., STI clinics or TB centers, where HIV diagnosis is confirmed). Counseling and testing in the context of PMTCT is coded under PMTCT.

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlets	Total number of service outlets providing counseling and testing according to national or international standards.	Program reports
Number of faith-based service outlets	Total number of faith-based service outlets providing counseling and testing. This is a subset of the total number of service outlets providing counseling and testing.	Program reports
Number of clients served	Total number of individuals who received counseling and testing, disaggregated by sex.	Program reports/HMIS
Number of persons trained	Total number of persons trained in counseling and testing according to national or international standards.	Program reports

Totals for Treatment Services

Definition: Activities including the provision of antiretroviral drugs and clinical monitoring for ART among those with advanced HIV infection in either an ART or a PMTCT+ setting.

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlets	Total number of service outlets providing treatment (ART and PMTCT+).	Program reports
Number of faith-based service outlets	Total number of faith-based service outlets providing treatment (ART and PMTCT+). This is a subset of the total number of service outlets providing treatment (ART and PMTCT+).	Program reports
Number of clients served	Total number of individuals receiving treatment (ART and PMTCT+), disaggregated by sex.	Program reports/HMIS
Number of persons trained	Total number of health workers trained, according to national and/or international standards, in the provision of treatment (ART and PMTCT+).	Program reports

Notes:

1. It is assumed that nearly 100% of all clients on treatment, through an ART or a PMTCT+ program, are also receiving palliative care services (see Palliative Care below). This assumption implies that some number of the total number of clients receiving palliative care will be the same individuals as the total number of clients receiving treatment.
2. If an HIV+ OVC is receiving treatment as well as care in an OVC program, the OVC should be counted both under treatment ***and*** under OVC.

Treatment: Antiretroviral Therapy

Definition: Activities including the provision of antiretroviral drugs and clinical monitoring for ART among those with advanced HIV infection. ART activities within the context of PMTCT+ are counted separately (see below).

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlets	Number of service outlets providing ART services according to national or international standards. *Note: Though the number of faith-based ART service outlets/programs is not required to be reported, these data will need to be collected so that total number of faith-based care, treatment and support programs can be reported.*	Program reports
Number of clients served	Number of individuals with advanced HIV infection receiving antiretroviral therapy, disaggregated by sex.	Program reports/HMIS
Number of **new** clients served	Number of **new** individuals with advanced HIV infection receiving antiretroviral therapy, disaggregated by sex. This is a subset of the number of individuals with advanced HIV infection receiving antiretroviral therapy.	Program reports/HMIS
Number of current clients in continuous services for more than 12 months	Number of current clients receiving continuous ART for more than 12 months, disaggregated by sex. This is a subset of the number of individuals with advanced HIV infection receiving antiretroviral therapy.	Program reports/HMIS
Number of persons trained	Number of health workers trained to deliver ART services according to national or international standards.	Program reports

Notes:

1. New = commenced since last reporting period.

Treatment: Prevention of Mother-to-Child Transmission Plus

Definition: Activities aimed at providing antiretroviral drugs within the minimum package of services for PMTCT+ including:

A. counseling and testing for pregnant women
B. ARV prophylaxis to prevent MTCT
C. counseling and support for safe infant feeding practices
D. family planning counseling or referral
E. ARV therapy for HIV+ women, their children, and their families

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlets	Number of service outlets providing the minimum package of PMTCT+ services according to national or international standards. *Note: Though the number of faith-based PMTCT+ service outlets is not required to be reported, these data will need to be collected so that total number of faith-based care, treatment and support programs can be reported.*	Program report
Number of clients served	Number of individuals with advanced HIV infection receiving ART at a designated PMTCT+ site, disaggregated by sex.	Program reports/HMIS
Number of **new** clients served	Number of **new** individuals with advanced HIV infection receiving ART at a designated PMTCT+ site, disaggregated by sex. This is a subset of the number of individuals with advanced HIV infection receiving ART at a designated PMTCT+ site.	Program reports/HMIS
Number of current clients in continuous services for more than 12 months	Number of current clients receiving continuous ART for more than 12 months at a designated PMTCT+ site, disaggregated by sex. This is a subset of the number of individuals with advanced HIV infection receiving ART at a designated PMTCT+ site.	Program reports/HMIS
Number of persons trained	Number of health workers trained to deliver ART services as part of PMTCT+ according to national or international standards.	Program reports

Totals for Palliative Care (non-ART care) Services/Programs

Definition: All clinic-based *and* home/community-based activities aimed at optimizing quality of life of HIV-infected (diagnosed or presumed) clients and their families throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management of opportunistic infections including TB and malaria and other HIV/AIDS-related complications; culturally-appropriate end-of-life care; social and material support, such as nutrition support, legal aid, and housing; and training and support for caregivers. Given the need to independently track TB prevention, care, and treatment in an HIV palliative care setting, totals for palliative care are made up of the two service categories below: Basic Health Care and Support, and TB/HIV.

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlets/programs	Total number of service outlets/programs providing general HIV-related palliative care including TB/HIV. *Note: Though the number of faith-based palliative care service outlets/programs is not required to be reported, these data will need to be collected so that total number of faith-based care, treatment and support programs can be reported.*	Program reports
Number of faith-based service outlets/programs	Total number of faith-based service outlets/programs providing HIV-related palliative care including TB/HIV. This is a subset of the total number of service outlets/programs providing general HIV-related palliative care including TB/HIV.	Program reports
Number of clients served	Total number of HIV-infected individuals receiving palliative care including TB/HIV, disaggregated by sex.	Program reports/HMIS
Number of persons trained	Total number of persons trained in providing palliative care for HIV-infected individuals including TB/HIV.	Program reports

Notes:

1. An HIV+ OVC receiving palliative care services among other services within an OVC program should *only* be counted under OVC to avoid double counting under the total care count.

Palliative Care (non-ART care): Basic Health Care and Support (excluding TB/HIV)

Definition: All clinic-based *and* home/community-based activities aimed at optimizing quality of life of HIV-infected (diagnosed or presumed) clients and their families throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management (and/or referral for these) of opportunistic infections ***(excluding TB/HIV)*** including malaria and other HIV/AIDS-related complications; culturally-appropriate end-of-life care; social and material support, such as nutrition support, legal aid, and housing; and training and support for caregivers. If palliative care programs are expanded to provide clients with ART, these clients would also be counted under Treatment. Palliative care activities that provide clinical management of TB are to be counted in the TB category (see next page).

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlets/programs	Number of service outlets/programs providing general HIV-related palliative care. *Note: Though the number of faith-based basic health care and support service outlets/programs is not required to be reported, these data will need to be collected so that total number of faith-based care, treatment and support programs can be reported.*	Program reports
Number of service outlets/programs providing malaria care and/or referral	Number of service outlets/programs providing malaria care and/or referral for HIV-infected clients (diagnosed or presumed) as part of general HIV-related palliative care. This number is a subset of the number of service outlets/programs providing general HIV-related palliative care.	Program reports
Number of clients served	Number of HIV-infected individuals (diagnosed or presumed) receiving general HIV-related palliative care, disaggregated by sex.	Program reports/HMIS
Number of persons trained	Number of persons trained in providing general HIV-related palliative care for HIV-infected individuals (diagnosed or presumed).	Program reports

Palliative Care: TB/HIV

Definition: Activities including exams, clinical monitoring, treatment, and prevention of tuberculosis in HIV palliative care settings as well as screening and referral for HIV testing, and clinical care related to TB clinical setting. If TB programs go beyond HIV testing to provide other palliative care services such as clinical or psychosocial services (see definition above), these would be counted in both this table and the Basic Health Care and Support (excluding TB/HIV) table above. If TB programs are expanded to provide clients with ART, these would also be counted under Treatment.

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlets	Number of service outlets providing clinical prophylaxis and/or treatment for TB according to national or international standards. *Note: Though the number of faith-based TB/HIV service outlets is not required to be reported, these data will need to be collected so that total number of faith-based care, treatment and support programs can be reported.*	Program reports
Number of clients served	Number of HIV-infected individuals receiving clinical care for TB, disaggregated by sex.	Program reports/HMIS
Number of persons trained	Number of persons trained in providing TB/HIV clinical care for HIV-infected individuals according to national or international standards.	Program reports

Orphans and Vulnerable Children

Definition: Activities aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality. The emphasis is on strengthening communities to meet the needs of orphans and vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, creating a supportive social environment. Activities could include training caregivers; increasing access to education; economic support; targeted food and nutrition support; legal aid; medical, psychological, or emotional care; and/or other social and material support. Institutional responses would also be included. If an HIV+ OVC is receiving treatment as well as care in an OVC program, the OVC should be counted both under treatment ***and*** under OVC. However, an HIV+ OVC receiving palliative care services among other services within an OVC program should ***only*** be counted under OVC to avoid double counting under the total care count.

Indicator type	**Indicator**	**Source/ Methodology**
Number of programs	Number of OVC programs.	Program reports
Number of faith-based programs	Number of faith-based OVC programs. This is a subset of the total number of OVC programs.	Program reports
Number of clients served	Number of OVC served by an OVC program, disaggregated by sex.	Program reports
Number of persons trained	Number of providers/caretakers trained in caring for OVC.	Program reports

Laboratory Infrastructure

Definition: Development and strengthening of laboratory facilities to support HIV/AIDS-related activities, including the purchase of equipment and/or commodities, the provision of quality assurance, staff training, and other technical assistance.

Indicator type	Indicator	Source/ Methodology
Number of service outlets	Number of laboratories with capacity to perform HIV tests and CD4 tests and/or lymphocyte tests.	Program reports
Number of persons trained	Number of persons trained in the provision of lab-related activities.	Program reports

Notes:

1. Number of test kits to be tracked in a separate procurement/commodities database.

Strategic Information

Definition: Activities related to HIV/AIDS surveillance, HMIS and M&E, including development of improved tools and models for collecting, analyzing, and disseminating HIV/AIDS behavioral and biological surveillance and monitoring information; facility surveys; other monitoring and health management information systems; assisting countries to establish and/or strengthen such systems; targeted program evaluations (including operations research); developing and disseminating best practices to improve program efficiency and effectiveness; planning/evaluating national prevention, care and treatment efforts; analysis and quality assurance or demographic and health data related to HIV/AIDS; and testing implementation models (e.g., to support the development or implementation of Global Fund proposals).

Indicator type	**Indicator**	**Source/ Methodology**
Number of persons trained	Number of persons trained in strategic information (includes M&E, surveillance, and HMIS).	Program reports

Other: Policy Analysis and System Strengthening (Capacity Building)

Definition: Other HIV/AIDS-related activities including strengthening policies and systems to address stigma and discrimination, and to support national prevention, care, and treatment efforts; other activities to strengthen systems or build capacity to combat HIV/AIDS, including activities to support the implementation of national and/or multilateral programs. Could include the provision of technical assistance through small grants or assistance with proposal development, organizational management, network or coalition building, advocacy, and/or public/private partnership building.

Indicator type	**Indicator**	**Source/ Methodology**
Number of service outlet/programs	Number of HIV service outlets/programs provided with technical assistance or implementing programs related to policy and/or capacity building including stigma and discrimination reduction programs.	Program reports
Number of faith-based service outlets/programs	Number of faith-based HIV service outlets/programs provided with technical assistance or implementing programs related to policy and/or capacity building. This is a subset of the total number of HIV service outlets/programs provided with technical assistance or implementing programs related to policy and/or capacity building including stigma and discrimination reduction programs.	Program reports
Number of persons trained	Number of persons trained in implementing programs related to policy and/or capacity building, including stigma and discrimination reduction programs.	Program reports

Outcome- and Impact-Level Indicators

Core Outcome- and Impact-Level Indicators

Indicator Type	Indicator Number	Indicator	Source/ Methodology	International Standard
Prevention				
Outcome	1	Percent of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Population-based survey	UNGASS, MDG
	2	Percent of never-married young people aged 15–24 who have never had sex	Population-based survey	Adapted from UNAIDS YPG
	3	Percent of never-married women and men aged 15–24 who had sex in the last 12 months, of all never-married women and men (aged 15–24) surveyed	Population-based survey	Adapted from UNAIDS
	4	Percent of women and men aged 15–49 who had sex with more than one partner in the last 12 months, of all people aged 15–49	Population-based survey	Adapted from UNAIDS
	5	Percent of women and men aged 15–49 who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months	Population-based survey	UNAIDS, MDG, UNAIDS YPG
	6	Percent of men reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse	Population-based survey	UNAIDS
	7	Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines	Special Study (MEASURE Evaluation blood safety protocol)	UNAIDS, GFATM
	8	Average number of medical injections per person per year	Population-based survey	WHO SIGN RARG
	9	Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package	Population-based survey	WHO SIGN RARG

Impact	10	Percent of young people aged 15–24 that are HIV-infected	Sentinel Surveillance, Sero-survey with biomarkers	Adapted from UNGASS, MDG
Prevention of Mother-to-Child Transmission				
Outcome	1	Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	HMIS+ modeling	UNGASS, GFATM
Impact	2	Percent of HIV-infected infants born to HIV-infected mothers	HMIS+ modeling	UNGASS
Counseling and Testing				
Outcome	1	Percent of the general population aged 15–49 receiving HIV test results in the last 12 months	Program reports+ modeling, Population survey, HMIS, health facility survey	Adapted from UNAIDS
Care, Support, and/or Treatment				
Outcome	1	Percent of people with advanced HIV infection receiving ART	Program reports+ modeling, HMIS	UNGASS, GFATM
	2	Percent of health care facilities that have the capacity and conditions to provide basic-level HIV testing and HIV/AIDS clinical management	Health facility survey	UNAIDS, UNAIDS C&S
	3	Percent of health care facilities that have the capacity and conditions to provide advanced-level HIV/AIDS care and support services, including provision of ART	Health facility survey	UNAIDS, UNAIDS C&S
	4	Percent of adults aged 18–59 who have been chronically ill for 3 or more months during the past 12 months, including those ill for 3 or more months before death whose households have received, free of user charges, basic external support in caring for the chronically ill person[10]	Population-based survey	Adapted from UNAIDS C&S

[10] Percent of adults 18-59 who have been chronically ill for 3 or more months during the past 12 months who have access to pain control and symptom management, among those who report pain and/or symptoms in the last 30 days, may also be desirable.

Impact	5	Percentage of people still alive at 6, 12, and 24 months after initiation of treatment	Periodic special studies: Cohort study	WHO 3x5
	6	Proportion of all deaths attributable to HIV	National mortality statistics, Sample Vital Registration through Verbal Autopsy (SAVVY)/DSS	The Emergency Plan Surveillance working group
OVC				
Outcome	1	Percent of orphans and vulnerable children under 18 living in households whose households have received, free of user charges, basic external support in caring for the child	Population-based survey	Adapted from UNAIDS, GFATM
Labs				
Outcome	1	Percent of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines	Laboratory study	UNAIDS C&S
Strategic Information				
Outcome	1	Percent of health facilities with record-keeping systems for monitoring HIV/AIDS care and support	Health facility survey	UNAIDS C&S

Other: Policy and Systems Strengthening (Capacity Building)				
Outcome	1	AIDS Program Effort Index	Special Study	UNAIDS, UNGASS
	2	Percent of the general population with accepting attitudes toward PLWHA	Population-based survey	Adapted from UNAIDS

Recommended Outcome- and Impact-Level Indicators

The following indicators are recommended at this point. Where an International Standard exists, it is indicated. Some of these indicators are appropriate at the sub-national level only, thus their exclusion from the core set of The Emergency Plan indicators. Some of the indicators have methodologies that are still under development. This is also indicated, as is the group leading the piloting or testing of the methodology.

Indicator Type	Indicator	Source/ Methodology	International Standard
Prevention[11]			
Outcome	Percent of patients with STIs at health care facilities who are appropriately diagnosed, treated and counseled	Special study (WHO/UNAIDS revised guidelines on evaluating STI services; Measure Service Provision Assessment)	UNAIDS, GFATM
Care, Treatment, and/or Support			
Outcome	Percent of HIV-positive patients who are given cotrimoxazole preventive therapy	Program reports/HMIS/special study	GFATM, CDC
	Percent of clients attending HIV testing and counseling who test positive and who are screened for TB symptoms	Program reports/HMIS/special study	GFATM, WHO TB/HIV working group
	Percent of all TB patients who are tested for HIV	Program reports/HMIS/special study	GFATM, WHO TB/HIV working group
	Percent of all HIV positive TB patients who are given ART	Program reports/HMIS/special study	GFATM, WHO TB/HIV working group
Impact	Quality of life for PLWHA	Periodic special studies: Cohort study (MOS-HIV scale, SF 12, which includes both physical and mental domains) *(Methodology under development)*	World Bank

[11] As The Emergency Plan expands into concentrated epidemic countries, specific high-risk group indicators looking at groups such as IDUs, CSWs, and MSM will become necessary.

	AIDS-related morbidity	HMIS AIDS case reporting + modeling, SAVVY *(Methodology under development)*	The Emergency Plan Surveillance working group
OVC			
Impact	Quality of life for OVC	Periodic special studies: Cohort study *(Methodology under development)*	World Bank
Strategic Information			
Outcome	Existence of national strategic information capacity for HIV/AIDS prevention, care, and treatment programs	Record review/ special study	UNAIDS C&S
	Percent of ARV distribution nodes that report on inventory consumption, quality, losses, and adjustments on a monthly basis	HMIS/special study	WHO 3x5
Other: Policy and Systems Strengthening (Capacity Building)			
Outcome	Existence of comprehensive HIV/AIDS policies, strategies, and guidelines[12]	Document review	UNAIDS C&S
	Percent of persons trained who: a. demonstrate they are applying competencies/skills; b. are placed in HIV/AIDS jobs they were trained for; and c. retain HIV/AIDS jobs after one year	Special study *(Methodology under development)*	IWG HCD work group

[12] Review of indicator for comprehensive policies, strategies, and guidelines would examine whether national policies exist AND if an operational plan has been developed. This would include the full range of prevention to care and treatment program areas (thus, all program areas of The Emergency Plan).

	Percent of persons (health care workers and/or others) with accepting attitudes toward PLWHA and/or Percent of persons (general population, health care workers, and/or others) reporting personal knowledge of someone who has experienced discrimination due to known or suspected HIV status	Special study *(Methodology under development)* Population-based survey, Special Study *(Methodology under development)*	IWG Stigma and Discrimination indicators working group
	Percent of large enterprises/companies that have HIV/AIDS workplace policies and programs	Workplace survey of largest companies in country	UNGASS, GFATM

CORE OUTCOME- AND IMPACT-LEVEL INDICATOR DEFINITIONS

Core: Prevention 1

Percent of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission

Rationale/What It Measures:	Assesses progress in achieving universal knowledge of the essential facts about HIV transmission
Definition:	Percentage of young women and men aged 15–24 who, in response to prompted questions, say that people can protect themselves from contracting HIV by having sex with only one faithful, uninfected partner, and using condoms, who know that a healthy-looking person can have the AIDS virus, and who correctly reject the two most common local misconceptions about AIDS transmission.
Measurement Tool:	Population-based survey such as DHS/AIS, MICS, BSS (youth)
Numerator:	Number of young women and men aged 15–24 who, in response to prompted questions, say that people can protect themselves from contracting HIV by having sex with only one faithful, uninfected partner, and using condoms and know that a healthy-looking person can have the AIDS virus, and who correctly reject the two most common local misconceptions about AIDS transmission.
Denominator:	Number of young women and men aged 15–24 surveyed
How To Measure It:	This indicator is constructed from responses to the following set of prompted questions: 1. Can the risk of HIV transmission be reduced by having sex with only one faithful, uninfected partner? 2. Can the risk of HIV transmission be reduced by using condoms? 3. Can a healthy-looking person have HIV? 4. *Can a person get HIV from mosquito bites?* (this is an example, local misconceptions should be questioned here) 5. *Can a person get HIV by sharing a meal with someone who is infected?* (this is an example, local misconceptions should be questioned here) Those who have never heard of HIV/AIDS should be excluded from the numerator but included in the denominator. Indicator scores are required for all respondents aged 15–24 years and should be reported separately for males and females, according to urban/rural residence. Scores for each of the individual questions (based on the same denominator) are required in addition to the score for the composite indicator.
Interpretation/	The belief that a healthy-looking person cannot be infected with HIV is a common misconception that can result in

Strengths and Weaknesses:	unprotected sexual intercourse with infected partners. Correct knowledge of false modes of HIV transmission is as important as correct knowledge of true modes of transmission. For example, the belief that HIV is transmitted through mosquito bites can weaken motivation to adopt safe sexual behavior, while the belief that HIV can be transmitted through sharing food reinforces the stigma faced by people living with AIDS. This indicator is particularly useful in countries where knowledge about HIV/AIDS is poor because it allows for easy measurement of incremental improvements over time. However, it is also important in other countries because it can be used to ensure that pre-existing high levels of knowledge are maintained. The "two most common misconceptions about AIDS transmission" will vary not only from country to country, but from survey to survey in the same country over time. This should be kept in mind when comparing this indicator across countries and over time.
Reference(s):	UNGASS (2002-Reference #6) National Program and Behavior Indicator 7; MDG (Reference #11) HIV/AIDS Indicator 19b (Targets**:** 2005 – 90%; 2010 – 95%)

Core: Prevention 2

Percent of never married young men and women aged 15–24 who have never had sex

Rationale/What It Measures:	This indicator is Part 1 of a composite ABC indicator that provides information on important aspects of sexual behavior. This particular indicator describes the proportion of never married young people surveyed who have never had sex, thus the prevalence of virginity among young people. Looking at this prevalence within narrow age ranges (15–16, 17–18, 19–20, 21–22, and 23–24, for example, or better yet, in single ages) across time allows program managers to see if the age at first sex is moving.
Definition:	Percent of never married young women and men aged 15–24 who have never had sex
Measurement Tool:	Population-based surveys such as DHS/AIS, RHS
Numerator:	Number of never married young women and men who have never had sex
Denominator:	Number of never married young women and men aged 15–24 surveyed
How To Measure It:	Respondents (15–24 year olds) are asked if they have ever had sex. The indicator should be reported separately for men and women. If the indicator is calculated for groupings of ages that are broader than the period of time that has passed, the indicator will not be able to reflect changes that may in fact be occurring. It is therefore recommended that this indicator be reported by single age.
Interpretation/ Strengths and Weaknesses:	Abstinence from sex, being faithful to one partner, and using condoms are the ways of preventing HIV infection that form the central message of USG programs. This indicator describes the extent to which abstinence is practiced among youth. In some settings, the proportion of those aged 20–24 who are never married will be very low, at least among women, and it may not be appropriate to construct the indicator for this age group in these cases. The other parts of the ABC composite should be considered as additional indicators as the composite shows movement of youth among the different behaviors if collected across time. Considering all six aspects of behavior together makes sense, as each component affects the other and each component is of progressively riskier behavior.
Reference(s):	Adapted from UNAIDS Young People's Guide (2004- Reference #13) Behavioral Indicator 3

Core: Prevention 3

Percent of never married women and men aged 15–24 who had sex in the last 12 months, of all never-married women and men (aged 15–24) surveyed

Rationale/What It Measures:	This indicator is a measure of premarital sex among young people. A high score on this indicator reflects a failure of prevention messages stressing abstinence until marriage. The converse of this indicator (that is, the indicator score subtracted from 100, functions as an indicator of abstinence among unmarried young people. Success in promoting abstinence should be reflected in a later age at first sex, as measured by Prevention Indicator 2. This indicator, however, captures an additional dimension: anyone who has been abstinent for more than a year (regardless of whether he/she has ever had sex). So the inverse indicator of abstinence will include not only virgins but also people who have given up sex for at least the last year as a protective measure against HIV and other STIs. Given that young people should be the focus of education and prevention programs, deciding to abstain from sex after having precocious sexual activity would be a desired program outcome.
Definition:	Percent of young never married women and men aged 15–24 who have had sexual intercourse in the last 12 months, of all young never-married respondents surveyed
Measurement Tool:	Population-based surveys such as UNAIDS general population survey, DHS/AIS, BSS (youth), RHS
Numerator:	Number of never married women and men aged 15–24 who have had sexual intercourse in the last 12 months
Denominator:	Number of never married women and men aged 15–24 surveyed
How To Measure It:	In a survey among people aged 15–24, respondents are asked about their marital status and their sexual partnerships. The indicator should be reported separately for men and women. It may also be constructed separately for those aged 15–19 and 20–24, as appropriate. In some settings, the proportion of those aged 20–24 who are never married will be very low, at least among women, and it may not be appropriate to construct the indicator for this age group in these cases.
Interpretation/ Strengths and Weaknesses:	This indicator has a critical role in advocacy. Resistance to improved sexual education and service provision for young people frequently comes from parents or other authorities who believe that abstinence until marriage is the only acceptable message for young people. An indicator that tracks premarital sex tracks the success or failure of this message and may point to gaps in the current approach. In addition, this indicator measures changes in what may be culturally and socially ascribed norms for early sexual activity. Where programs are advocating a delay of first sex or abstinence outside of a married, monogamous relationship, the indicator should show an decrease. A limitation may be that small sample sizes of the different age strata could make analysis and interpretation of results quite difficult. As well, in areas where early marriage is both encouraged and acceptable, prevention programs may have limited

	effect on changing prevailing social and cultural norms around marriage.
Reference(s):	Adapted from UNAIDS (2000-Reference #7) Young People's Sexual Behavior Indicator 2

Core: Prevention 4

Percent of women and men aged 15–49 who had sex with more than one partner in the last 12 months, of all people aged 15–49 surveyed

Rationale/What It Measures:	Prevention messages should focus on abstinence and also on mutual monogamy. But because sexual relationships among young people are frequently unstable, relationships that were intended to be mutually monogamous may break up and be replaced by other relationships in which similar intentions prevail. Particularly in high HIV prevalence epidemics, serial monogamy is not greatly protective against HIV infection. This indicator measures the proportion of people that have been exposed to more than one partner in the last year.
Definition:	Percent of women and men aged 15–49 who have had sex with more than one partner in the last 12 months, of all people aged 15–49 surveyed
Measurement Tool:	Population-based surveys such as UNAIDS general population survey, DHS/AIS, BSS (youth), RHS
Numerator:	Number of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months.
Denominator:	Number of women and men aged 15–49 surveyed
How To Measure It:	In a survey among people aged 15–49, respondents are asked about their sexual partnerships in the last year. The indicator should be reported separately for men and women. It should also be constructed separately for those aged 15–19, and 20–24, 15–24, and 15–49.
Interpretation/ Strengths and Weaknesses:	This indicator does not distinguish between marital and non-marital partners. It tracks all multiple partnerships, regardless of their relative levels of risk. In the very similar adult sexual behavior indicator (Sexual Behavior Indicator 1), a distinction is made between marital and cohabiting partners, and all other partner types. This is partly to cope with the measurement challenge posed by men in polygamous societies, who may have multiple partners within marriage. However, polygyny among men under 25 is extremely rare. It is therefore not necessary to disaggregate for young people. The indicator also suffers from the expected respondent and social desirability bias. For young people saturated with prevention messages, there will be high motivation to under-report partners. Likewise, social pressure for women to give untruthful answers may be strong.
Reference(s):	Adapted from UNAIDS (2000-Reference #7) Young People's Sexual Behavior Indicator 4

Core: Prevention 5

Percent of women and men aged 15–49 who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months

Rationale/What It Measures:	If everyone used a condom every time they had sex with a non-marital or non-cohabiting partner, a heterosexually transmitted HIV epidemic would be almost impossible to sustain. While AIDS programs may try to reduce casual partnerships, they must also, if they are to succeed in curbing the epidemic, promote condom use in the casual partnerships that remain. This indicator tracks changes in condom use in these partnerships.
Definition:	Percent of women and men aged 15-49 who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months
Measurement Tool:	Population-based surveys such as UNAIDS general population survey, DHS/AIS, BSS (adult), RHS
Numerator:	Number of those women and men in the denominator who used a condom the last time they had sex with their *most recent* non-marital, non-cohabiting partner
Denominator:	Number of women and men aged 15–49 who report at least one non-marital, non-cohabiting partner in the last 12 months
How To Measure It:	For each partner listed in the last 12 months, respondents are asked whether they used a condom the last time the couple had sex. Other questions will allow for the classification of partnerships as non-marital and non-cohabiting. The indicator should be reported separately for men and women. It should also be constructed separately for those aged 15–24 and 15–49.
Interpretation/ Strengths and Weaknesses:	A rise in this indicator is an extremely powerful indication that condom promotion campaigns are having the desired effect among those high-risk individuals with multiple partners. Since condom promotion campaigns aim for consistent use of condoms with non-regular partners rather than simply occasional use, some surveys have tried to ask directly about consistent use, often using an always/sometimes/never question. While this may be useful in sub-population surveys, it is subject to recall bias and other biases and is not sufficiently robust for use in a general population survey. Asking about the most recent act of non-marital, non-cohabiting sex minimizes recall bias and gives a good cross-sectional picture of levels of condom use. It is recognized that consistent use of condoms is an important goal. But inevitably, if consistent use rises, this indicator will also rise. An increase over time of this indicator does not necessarily mean an increase in "safe sex" practices; the percentage of non-marital, non-cohabiting partners may be decreasing. This indicator should be analyzed in combination with an estimate of the percentage of respondents having sex with a non-marital, non-cohabiting partner.

Reference(s):	UNAIDS (2000-Reference #7) Sexual Behavior Indicator 2; MDG (Reference #11) HIV/AIDS Indicator 19a; Adapted from UNAIDS Young People's Guide (2004-Reference #13) Behavioral Indicator 2, denominator is UNAIDS (2000-Reference #7) Sexual Behavior Indicator 1

Core: Prevention 6

Percent of men reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse

Rationale/What It Measures:	This indicator gives an indication of the success or failure of campaigns to increase condom use among clients of sex workers. It measures condom use by men with partners they consider to be commercial partners.
Definition:	Percent of men aged 15–49 reporting condom use the last time they had sex with a sex worker, of those who report having had sex with a sex worker in the last 12 months
Measurement Tool:	Population-based surveys such as UNAIDS general population survey, DHS/AIS, BSS (adult), RHS
Numerator:	Number of men who report that they used a condom at last sex with a commercial sex worker or when they last paid someone in exchange for sex
Denominator:	Number of men 15–49 who had sex with a commercial sex worker or paid someone in exchange for sex in the last 12 months
How To Measure It:	In general population surveys or in specialized surveys among groups of men who fit the profile of clients of sex workers (e.g., members of the military, truck drivers), men are asked if they have paid someone in exchange for sex in the last 12 months. If they reply yes, they are further asked whether they used a condom the last time they did so.
Interpretation/ Strengths and Weaknesses:	This indicator is invaluable in tracking the success of major programs to promote condom use in commercial sex. Most AIDS programs aim to increase consistent use of condoms with sex workers. Surveys of clients of sex workers will almost certainly want to ask whether they use a condom always, sometimes, or never in sex with sex workers over the last 12 months. However the pressure to say "always" is strong. Asking about a particular, and recent, act of sex may give a more robust measure of levels of condom use in commercial sex. However, it is strongly recommended that programs focusing prevention resources on increasing condom use in commercial sex also construct an indicator of consistent use of condoms in commercial sex. Where there are several distinct populations of sex workers with different levels of perceived risk—for example, brothel-based prostitutes may be thought of as having riskier behavior than commercial sex workers in nightclubs—data may be collected separately for separate categories of sex worker. This can provide important information for programming. For example, men may report very high levels of consistent condom use in brothels, but much lower levels with commercial sex workers working out of nightclubs. This may be a warning signal for a shift of the high prevalence from one group to another. In constructing the indicator, however, only the last commercial sex partner of any sort should be considered.

	It is very difficult to define commercial sex in a way that translates from one place to another and this is the major limitation of this indicator. Once commercial sex has been described for a country, however, this is unlikely to change much over time. An increase over time of this indicator does not necessarily mean an increase in "safe sex" in commercial sex; the percentage of men having sex with commercial sex workers may be decreasing. This indicator should be analyzed in combination with an estimate of the percentage of men having sex with a commercial sex partner.
Reference(s):	UNAIDS (2000-Reference #7) Sexual Behavior Indicator 4, denominator is UNAIDS (2000-Reference #7) Sexual Behavior Indicator 3

Core: Prevention 7

Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines

Rationale/What It Measures:	Blood safety programs aim to ensure that the overwhelming majority (ideally 100 percent) of blood units are screened for HIV, and those that are included in the national blood supply are indeed uninfected. This is demonstrably not the case in many countries. Some blood units are not screened at all; others are screened by poorly trained personnel using outdated equipment or insufficient inputs. What's more, poor blood testing facilities mean that some blood is screened using antibody tests at a time after the donor has become infected with HIV but before he/she has developed antibodies to the virus. Together, these factors mean that a significant proportion of blood units may be classified as safe even though they are infected. This indicator gives an idea of the overall percentage of blood units that have been screened to high enough standards that they can confidently be declared free of HIV.
Definition:	Percent of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines
Measurement Tool:	MEASURE *Evaluation* blood safety protocol (Special study)
Numerator:	(see below)
Denominator:	(see below)
How To Measure It:	Three pieces of information are needed for this indicator: the number of blood units transfused in the previous 12 months; the number of blood units screened for HIV in the previous 12 months; and among the units screened, the number screened up to WHO or national standards. The number of units transfused and the number screened for HIV should be available from health information systems. Quality of screening may be determined from a special study that re-tests a sample of blood previously screened, or from an assessment of the conditions under which screening occurred. In situations where this approach is not feasible, data on the percentage of facilities with good screening and transfusion records and no stock outs of test kits may be used to estimate adequately screened blood for this indicator.
Interpretation/ Strengths and Weaknesses:	Where sufficient information exists to construct it, this measure is a strong indicator of the overall safety of the blood supply. However, changes in the indicator could reflect changes in the proportion of blood units screened or changes in the quality of the screening process. A successful campaign to reduce unnecessary transfusions may also be reflected in the indicator, since the overall number of transfused units would fall and the proportion of those screened to WHO/national standards should rise in consequence. However, the different elements of the indicator should therefore be reported separately for

	programmatic purposes. Where health systems are decentralized, or where the private sector is involved in blood screening and blood banking, it may be difficult to obtain good enough information to construct a robust indicator on a national scale. In this case, it may be necessary to select sentinel hospitals and laboratories in both the public and the private sector for facility-based surveys of blood transfusion and screening quality.
Reference(s):	UNAIDS (2000-Reference #7) Blood Safety Indicator 1; GFATM Toolkit (2004-Reference #12) Prevention Indicator 11

Core: Prevention 8

Average number of medical injections per person per year

Rationale/What It Measures:	Injection overuse contributes to the transmission of blood borne pathogens through health care injections as it amplifies the effect of unsafe practices. This indicator captures the number of injections received each year to document trends in the effectiveness of interventions to decrease injection overuse.
Definition:	Average number of medical injections per person (women and men aged 15-49) per year
Measurement Tool:	Population-based survey such as the DHS/AIS
Numerator	Number of injections administered by a doctor, a nurse, a pharmacist, or any other health worker to all respondents aged 15-49 in the last 6 months
Denominator	Number of women and men aged 15-49 surveyed
How to measure it:	In a population survey men and women aged 15-49 are asked: • if they have had any injections for any reason in the last six months; • if yes, how many. Frequency of injections in six months is multiplied by two to arrive at the frequency for the year. It should be noted that medical injections can be self-administered (e.g., insulin for diabetes). These injections should be included in the numerator. The indicator should be reported separately for men and women.
Interpretation/ Strengths and Weaknesses:	The distribution of the frequency of injections received is usually skewed to the right. A small proportion of the population (e.g., diabetics) receives a substantial proportion of all injections. Thus, population surveys using a small sample size may underestimate the annual number of injections per person because none of the persons receiving many injections were included in the sample.
Reference(s):	WHO Injection practices: Rapid assessment and response guide (2002-Reference #14). (Target: $\leq$1 injection per person per year)

Core: Prevention 9

Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package

Rationale/What It Measures:	Reuse of injection equipment in health care setting is a potential vector of HIV/AIDS. Thus, the proportion of injections given with reused injection equipment is an important prevention indicator in an initiative to prevent and control HIV AIDS.
Definition:	Proportion of women and men age 15-49 reporting that the last health care injection was given with a syringe and needle set from a new, unopened package
Measurement Tool:	Population survey such as DHS/AIS
Numerator	Number of those men and women from the denominator who mention that the last injection received was given with a syringe and needle set from a new, freshly opened package
Denominator	Number of men and women aged 15-49 who can recall receiving an injection in the last six months
How to measure it:	In a population survey men and women aged 15-49 are asked: • if they have had any injections for any reason in the last six months; • if yes, how many; • among those injections, how many were administered be a doctor, nurse, pharmacist, dentist, or any other health worker; • where the last injection was given; and • for the last injection, did the person who gave the injection take the syringe and needle from a new, unopened package.
Interpretation/ Strengths and Weaknesses:	Population-based surveys provide a good surrogate measure of the proportion of reuse of injection equipment. Results of combined assessments of injection practices that have used both observational and population-based survey approaches indicate that there is a good correlation between the results obtained with the two methods. Persons interviewed who recall receiving an injection in the last year but who do not remember the circumstances of it should not be included in the numerator and should not be excluded from the denominator. This lack of recall is an indication of an absence of consumer demand.
Reference(s):	*WHO Injection practices: Rapid assessment and response guide* (2002-Reference #14); WHO Injection Safety CD ROM: *His life and her trust are in your hands*. WHO/HTP/EHT

Percent of young people aged 15–24 that are HIV-infected

Rationale/What It Measures:	Assesses progress toward eradicating HIV infection
Definition:	Percent of young people aged 15–24 that are HIV-infected
Measurement Tool:	1. *HIV sentinel surveillance*: it is recommended that this indicator is measured through use of existing ANC-based sentinel surveillance data (15-24 year old pregnant women) and epidemiologic models (EPP). WHO guidelines. 2. *General Population Survey*: Where feasible, the indicator should be periodically measured directly through serological survey of the general population (women and men age 15-24), during DHS-type or AIS-type surveys. This allows sex-specific, age-specific estimates to be produced. NOTE: Numerator and denominator definitions below refer to the direct measurement approach (see below).
Numerator:	Number of persons age 15-24 who tested positive for HIV
Denominator:	Number of persons age 15–24 tested for their HIV infection status
How To Measure It:	*Sentinel Surveillance and Modeling*: This indicator is calculated using data from pregnant women attending ANC in HIV sentinel surveillance sites in the capital city, other urban areas, and rural areas. Aggregated national estimates of age-specific trends in HIV prevalence are obtained through epidemiologic modeling (EPP) *Direct estimation*: HIV tests are performed on a probability sample of women and men in the reference age group, during a DHS-type or AIS-type general population survey. Indicator estimates should be given for the whole age range (15–24 years) and disaggregated by five-year age group (15–19 and 20–24), sample size permitting. Should direct estimates be available (i.e. from general population survey), male and female estimates should be given separately. Because of the different methodologies used, estimates obtained from ANC sentinel surveillance and those from general population surveys should not be combined to ascertain trends.
Interpretation/ Strengths and Weaknesses:	HIV prevalence at any given age is the difference between the cumulative numbers of people who have become infected with HIV up to this age and the number who died, expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those

	individuals most vulnerable and rising mortality rather than behavioral change. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behavior. Thus, reductions in HIV incidence associated with genuine behavioral change may first become detectable in HIV prevalence figures for the 15–19 age group. Where available, parallel behavioral surveillance survey (BSS) data should be used to aid interpretation of trends in HIV prevalence. In countries where first sexual intercourse occurs at an older age and/or levels of contraception are high, HIV prevalence among pregnant 15–24-year-old women will differ from that among all women in the age group. This indicator gives a fairly good estimate of relatively recent trends in HIV infection in locations where the epidemic is heterosexually driven. It is less reliable as an indicator of HIV epidemic trends in locations where most infections remain temporarily confined to sub-populations with high-risk behaviors.
Reference(s):	Adapted from UNGASS (2002-Reference #6) Impact Indicator 1; MGD (Reference #11) Indicator 18 (Targets: 2005 – 25% reduction; 2010 – 50% reduction)

Core: PMTCT 1

Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT

Rationale/What It Measures:	Assesses progress in preventing mother-to-child HIV transmission
Definition:	Percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT
Measurement Tool:	Program monitoring (HMIS) and estimates (modeling)
Numerator:	Number of HIV-infected pregnant women provided with a full course of antiretroviral prophylaxis to reduce MTCT according to the nationally approved treatment protocol (or WHO/UNAIDS standards) in the last 12 months (program reports or HMIS)
Denominator:	Estimated number of HIV-infected pregnant women (modeled)
How To Measure It:	The number of HIV-infected pregnant women provided with antiretroviral prophylaxis to reduce the risk of MTCT in the last 12 months is obtained from program monitoring records. Only those women who completed the full course should be included. The definition of a 'full course' of antiretroviral prophylaxis will depend on the country's policy on antiretroviral prophylaxis to reduce the risk of MTCT and may or may not include a dose for newborns. Details of the definition used should be provided. The number of HIV-infected pregnant women to whom antiretroviral prophylaxis to reduce the risk of MTCT *could potentially have been given* is estimated by multiplying the total number of women who gave birth in the last 12 months (Central Statistics Office estimates of births) by the most recent national estimate of HIV prevalence in pregnant women (HIV sentinel surveillance antenatal clinic estimates). The decision as to whether or not to include women who receive treatment from private-sector and NGO clinics in the calculation of the indicator is left to the discretion of the country concerned. However, the decision taken should be noted and applied consistently in calculating both the numerator and the denominator. Private-sector and NGO clinics that provide prescriptions for antiretrovirals but assume that the drugs will be acquired by the individuals elsewhere are not included in this indicator, even though such clinics may be major providers of MTCT-reduction services. Separate estimates of the numbers of pregnant women provided with antiretroviral prophylaxis at public- and private-sector clinics should be given. The indicator should be constructed separately for those aged 15–24 and 15–49.

Interpretation/ Strengths and Weaknesses:	In many countries, the estimate of HIV prevalence among pregnant women used in the calculation of this indicator will be based on antenatal clinic-based HIV surveillance data. In some of these countries, large numbers of pregnant women do not have access to ANC services or choose not to make use of them. Pregnant women with HIV may be more or less likely to use ANC services (or public rather than private ANC services) than those who are not infected, particularly where antiretroviral prophylaxis can be accessed via such services. In such circumstances, this indicator should be interpreted with reference to recent estimates of utilization of national ANC services. HIV testing and counseling for HIV, and antiretroviral prophylaxis to reduce MTCT can be made available but, ultimately, it is up to individual women to decide whether or not to make use of these services. Thus, a country's score on this indicator will reflect the degree of interest in these services (partly a function of the way in which they are promoted), as well as the extent to which they are available. Countries will apply different definitions as to what constitutes a 'full course' of antiretroviral prophylaxis. Thus, inter-country comparisons may not be entirely valid and should be interpreted with reference to details of the different definitions used in each case. This indicator does not measure compliance with the antiretroviral treatment regime because it is not possible to monitor drug compliance, unless direct supervision is undertaken.
Reference(s):	UNGASS (2002-Reference #6) National Program and Behavior Indicator 4; GFATM Toolkit (2004 Reference #12) Prevention Indicator 8

Core: PMTCT 2

Percent of HIV-infected infants born to HIV-infected mothers

Rationale/What It Measures:	Assesses progress toward eliminating mother-to-child HIV transmission
Definition:	Percent of HIV-infected infants born to HIV-infected mothers
Measurement Tool:	Estimates based on program coverage (HMIS+ modeling)
Numerator:	(see below)
Denominator:	(see below)
How To Measure It:	The indicator is calculated by taking the weighted average of the probabilities of MTCT for pregnant women receiving and not receiving antiretroviral, the weights being the proportions of women receiving and not receiving ARV, respectively. Expressed as a simple mathematical formula: **Indicator score = { T*(1-e) + (1-T) } * v** *where:* **T** = proportion of HIV-infected pregnant women provided with antiretroviral treatment **v** = MTCT rate in the absence of any treatment **e** = efficacy of treatment provided **T** = the value for PMTCT Indicator 1 Default values of 25% and 50%, respectively, can be used for **v** and **e.** However, where scientific estimates of the efficacy of the specific forms of antiretroviral treatment (e.g., nevirapine) used in the country are available, these can be used in applying the formula. When this is done, the values of these estimates should be recorded. The most common forms of treatment provided during the last 12 months should be noted.
Interpretation/ Strengths and Weaknesses:	This indicator focuses on prevention of MTCT of HIV through increased provision of antiretroviral prophylaxis. Thus, the effect of breastfeeding on MTCT of HIV is ignored and the indicator may yield underestimates of true rates of MTCT in countries where long periods of breastfeeding are common. Similarly, in countries where other forms of prevention of MTCT of HIV (e.g., caesarean section) are widely practiced, the indicator will typically provide overestimates of MTCT. For these reasons, trends in this indicator may not reflect overall trends in MTCT of HIV.

	PMTCT Indicator 1 may provide a poor estimate for **T** in circumstances where usage of antenatal clinic services is low.
Reference(s):	UNGASS (2002-Reference #6) Impact Indicator 2 (Targets: 2005 – 20% reduction; 2010 – 50% reduction)

Percent of the general population aged 15–49 receiving HIV test results in the last 12 months

Rationale/What It Measures:	HIV testing and counseling are important entry points for prevention and care needs. Measuring the number of people who access these services is therefore important to indicate the number of people who could potentially benefit from prevention and care. In addition, over time this indicator provides information on the number of new people tested. This indicator is designed to show how many people have been tested and received their results in the last 12 months. This indicator can be used as a proxy for the coverage of HIV counseling and testing services. Estimates of coverage of counseling and testing services help to determine whether those services are achieving their threefold aims of providing an entry point for care and support, promoting safe behavior, and breaking the cycle of silence and stigma. This indicator aims to give an idea of the reach of HIV testing services in the general population and of the percentage of people who now know their HIV status. It can also be constructed for specific sub-populations with high-risk behavior among whom counseling and testing services are being promoted.
Definition:	Percentage of women and men aged 15–49 who have been tested for HIV in the last 12 months and received their test results the last time they were tested
Measurement Tool:	Ideally, these data would be collected regularly and aggregated at the national level through a strong health management information system, but this may not yet be possible in all settings. Alternative methods for collecting this information include health facility surveys and population-based surveys such as the UNAIDS general population survey; DHS/AIS; and/or BSS (adult + youth).
Numerator:	Number of women and men aged 15–49 who report receiving HIV test results in the last 12 months
Denominator:	Number of women and men aged 15–49 surveyed
How To Measure It:	In a general population or sub-population survey, respondents are asked whether they were tested in the last 12 months, and, if so, whether they have received the results. The questionnaire prefaces the questions by saying, "I do not want to know the results of the test…", in an attempt to minimize stigma-based fear of answering the questions truthfully. The indicator needs to be stratified by how these services are delivered. Distinguishing how counseling and testing are provided is important to service delivery. In general, three service delivery methods should be considered: stand-alone or free-standing voluntary counseling and testing sites; counseling and testing units within health facilities to which people are

	referred (from tuberculosis, family planning and other health units, for example); and fully integrated counseling and testing services in which a provider can refer the person to a laboratory for a test, but the provider carries out the counseling. Age should also be stratified to determine what age ranges are accessing and receiving these services. The age ranges could be: 15–24, 25–34 and 35–49 years. The indicator should be reported separately for men and women.
Interpretation/ Strengths and Weaknesses:	Because testing and counseling services are often not performed within discrete units (that is, outpatient or inpatient departments) or departments, reports can potentially be duplicated for the same individual being tested in multiple units or those being tested multiple times during the 12-month period. In other cases, such as preventing the mother-to-child transmission of HIV and other HIV testing and counseling, services are performed in the same place. This too will lead to double reporting in the number of people tested. In addition, because of these various points of HIV testing and counseling services, linking testing to counseling through facility records may be difficult in some situations unless a strong records system is in place to track testing and counseling. If a household survey is used, double counting can be minimized. In areas where HIV is highly stigmatized, respondents may be unwilling even to admit to having taken an HIV test, since it may be counted an admission that they fear they may be infected. This is all the more true when the question is posed in the context of a questionnaire about risk behavior. On the other hand, in countries where testing has been heavily promoted as a "responsible" thing to do, some people may say they have been tested when in fact they have not. Despite these potential biases, the indicator is useful for getting a rough idea of the proportion of people likely to know their HIV status at all. Because the indicator is constructed to capture the percentage of respondents receiving an HIV test and receiving results *in the last 12 months*, the measure will reflect recent changes in testing services. Those people at higher risk for HIV should be targeted for repeat testing. Note, however, that in high-prevalence populations with good coverage of testing services, trends in the time-bound indicator can be expected to be affected by the fact that people who have tested HIV positive will not return for further testing in future years. A breakdown of the indicator into its component parts (looking, for example, at people who received a test but never received their results) can point to gaps in program service provision and quality of care. Data on those who do not return for results or know their results may offer insight, for example, into levels of stigma and/or reluctance to learn their HIV status based on lack of available options for care. Due to the difficulty in defining post-counseling and ethical issues in asking questions on post-counseling associated with HIV+ status, no information on post-counseling should be collected through population surveys. Additional information on

	post-test counseling should be collected through alternative methodologies such as facility-based surveys. At the local level, program managers may be interested in collecting additional information, such as the number of people tested and counseled, the number receiving their results of those tested, and the number found to be HIV positive of those tested.
Reference(s):	Adapted from UNAIDS (2000- Reference #7) Voluntary Counseling and Testing Indicator 1; and UNAIDS Care & Support Guide (2004-Reference #8) Indicator CS1

Percent of people with advanced HIV infection receiving ART

Rationale/What It Measures:	Assesses progress in providing antiretroviral combination therapy to all people with advanced HIV infection
Definition:	Percent of people with advanced HIV infection receiving ART
Measurement Tool:	Program monitoring (Program reports+ modeling, HMIS)
Numerator:	Number of people with advanced HIV infection who receive antiretroviral combination therapy according to the nationally approved treatment protocol (or WHO/UNAIDS standards) (service statistics from program reports or HMIS)
Denominator:	Estimated number of people with advanced HIV infection (modeled, see below)
How To Measure It:	The number of people (i.e., adults and children) with advanced HIV infection who currently receive antiretroviral combination therapy can be calculated as follows: A: Number of people receiving treatment at start of year **+** B: Number of people who commenced treatment in the last 12 months **–** C: Number of people for whom treatment was terminated in the last 12 months (including those who died). For the purpose of this indicator, the number of people with advanced HIV infection is taken to be 15% of the total number of people currently infected. The latter is estimated using the most recent national sentinel surveillance data. Private-sector antiretroviral provision should be included in the calculation of the indicator wherever possible, and the extent of such provision should be recorded separately. The start and end dates of the period for which the antiretroviral combination therapy is given should be stated. Overlaps between reporting periods should be avoided wherever possible. The indicator should be reported separately for men and women.
Interpretation/ Strengths and Weaknesses:	The indicator permits monitoring of trends in coverage, but does not attempt to distinguish between different forms of antiretroviral therapy, or to measure the cost, quality, or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time.

	The proportion of people with advanced stages of HIV infection will vary according to the stage of the HIV epidemic and the cumulative coverage and effectiveness of antiretroviral therapy among adults and children. The proportion currently recommended for use in calculating this indicator (15%) is a crude estimate and may be subject to revision. This figure is particularly relevant in situations where the current coverage of antiretroviral combination therapy is low. The degree of utilization of antiretroviral therapy will depend on cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of VCT services, perceptions of effectiveness, and possible side effects of treatment. Preventative antiretroviral therapy for the purpose of prevention of MTCT and post-exposure prophylaxis are not included in this indicator.
Reference(s):	UNGASS (2002-Reference #6) National Program and Behavior Indicator 5; GFATM Toolkit (2004-Reference #12) Treatment Indicator 1

Core: Care, Treatment, and/or Support 2

Percent of health care facilities that have the capacity and conditions to provide basic-level HIV testing and HIV/AIDS clinical management

Rationale/What It Measures:	Many facilities that provide general curative care are also providing services related to HIV/AIDS and are caring for people living with HIV/AIDS. This may occur in settings that have no specific HIV/AIDS program. For facilities that are providing these services, evaluating the degree to which capacity exists to carry out these HIV services is therefore important. The HIV/AIDS specific services and components identified and defined by this indicator are those that both support HIV/AIDS services and can reasonably be expected to exist in almost any health facility.
Definition:	Percentage of health facilities that have the capacity and conditions to provide basic HIV counseling and testing and to manage HIV/AIDS clinical services. Capacity to provide basic HIV counseling and testing and health services is defined as: a. a system for testing and providing results for HIV infection; b. systems and qualified staff for pre- and post-test counseling; c. specific health services relevant to HIV/AIDS, including resources and supplies for providing these services; d. elements for preventing nosocomial infections; and e. trained staff and resources providing basic interventions for prevention and treatment for people living with HIV/AIDS.
Measurement Tool:	This information should be collected through a health facility survey. The recommended tool is the piloted Service Provision Assessment covering all relevant service areas. HIV/AIDS service providers should also be interviewed.
Numerator:	1. Number of facilities at which the individual items for each service or item listed above exist 2. Number of facilities at which all components for each individual service or item (a, b, c, d **or** e) exist 3. Number of facilities at which all components for all individual services and items (a, b, c, d **and** e) exist
Denominator:	For 1, the total number of health facilities surveyed For 2 and 3, the total number of health facilities at which HIV/AIDS services in each of the areas identified in the definition are offered or relevant
How To Measure It:	This information should be collected through a health facility survey in all relevant service areas. HIV/AIDS service providers should also be interviewed. See Annex 1 of the UNAIDS C&S M&E Guide for details of the individual items identified for each of these, including detailed measurement instructions.

Interpretation/ Strengths and Weaknesses:	Although the objective is to determine the percentage of facilities that have all items within all service and item areas (a, b, c, d and e), few, if any, facilities will have this level of services. In many settings, facilities do not have all items for each service. The specific items to support each service should therefore be presented individually. This indicator does not provide individual information for voluntary counseling and testing services or for services for preventing the mother-to-child transmission of HIV except if: 1) the services are integrated within the health facility; and 2) the components of these services are relevant to the areas assessed. The list of components (for Part a) also excludes facilities that only conduct or refer for pre-employment HIV tests, excludes testing blood prior to transfusion, and excludes facilities that refer people living with HIV/AIDS to another facility for assessment and testing if the referral facility is responsible for further services.
Reference(s):	UNAIDS Care & Support Guide (2004-Reference #8) Indicator CS6

Core: Care, Treatment, and/or Support 3

Percent of health care facilities that have the capacity and conditions to provide advanced-level HIV/AIDS care and support services, including provision of ART

Rationale/What It Measures:	This indicator measures the availability of advanced services specific to people living with HIV/AIDS. It is assumed that the services and items measured in this indicator require substantial input and personnel training beyond what is routine for most health systems.
Definition:	Capacity to provide advanced HIV/AIDS care is defined as: a. systems and items to support the management of opportunistic infections and the provision of palliative care (symptomatic treatment) for the advanced care of people living with HIV/AIDS; b. systems and items to support advanced services for the care of people living with HIV/AIDS; c. systems and items to support antiretroviral combination therapy (including security measures for the ARVs); d. conditions to provide advanced inpatient care for people living with HIV/AIDS; e. conditions to support home-care services; and f. post-exposure prophylaxis.
Measurement Tool:	This information should be collected through a health facility survey with observation in all relevant service areas. Like Care, Treatment, and/or Support Indicator 2, interviews of HIV/AIDS service providers would also be needed.
Numerator:	1. Number of facilities at which the individual items for each service or item listed above exist 2. Number of facilities at which all components for each individual service or item (a, b, c, d, e, **or** f) exist 3. Number of facilities at which all components for all individual services and items (a, b, c, d, e, **and** f) exist
Denominator:	For 1, the total number of health facilities surveyed For 2 and 3, the total number of health facilities at which HIV/AIDS services in each of the areas identified in the definition are offered or relevant
How To Measure It:	The specific items for each service should be presented individually and at a first level of aggregation (all components of each service or item). When a reasonable proportion of facilities begin to have all first-level aggregated components, a second-level aggregation can be presented when appropriate. See Annex 1 of the UNAIDS C&S for details of the individual items identified for each of these, including detailed measurement instructions.
Interpretation/ Strengths and	This indicator examines advanced HIV/AIDS services among all health facilities. In some settings, facilities will not have all items for each item or component, and countries may have different strategies for providing select advanced services at only

Weaknesses:	certain levels of the health care system (that is, referral hospitals may offer a wider range of advanced care than health centers). Although this indicator does not stratify by level of health care facility, managers of national AIDS programs can analyze this information if desired.
Reference(s):	UNAIDS Care & Support Guide (2004-Reference #8) Indicator CS7

Percent of adults aged 18–59 who have been chronically ill for 3 or more months during the past 12 months, including those ill for 3 or more months before death, whose households have received, free of user charges, basic external support in caring for the chronically ill person

Rationale/What It Measures:	This indicator attempts to quantify the extent of support services free of user charges to households with chronically ill people.
Definition:	Percentage of adults aged 18–59 who have been chronically ill for 3 or more months in the past 12 months, including those ill for 3 or more months before death, whose households received, free of user charges, basic external support in caring for chronically ill people, including health, psychological, or emotional, and other social and material support External support for chronically ill adults is defined as: • Medical support; • Emotional and psychological: counseling from a trained counselor, companionship, and emotional or spiritual support; • Material including socioeconomic (clothing, extra food or financial support); and • Other social support or instrumental (help with household work, training for a caregiver or legal services). External support is defined here as help free of user charges coming from a source other than friends, family or neighbors unless they are working for a community-based group or organization. In settings in which friends, family, or neighbors provide most external support, program managers may consider adapting this. The definition of chronically ill varies from setting to setting. Developing and noting a commonly agreed upon definition prior to initiating work are therefore important.
Measurement Tool:	Population-based survey such as the UNAIDS general population survey; DHS/AIS; BSS (adult + youth)
Numerator:	Women and men aged 18–59 who have been ill for 3 or more months during the past 12 months and whose household received the following support: 1. Medical support at least once a month during illness AND 2. Emotional support in the last 30 days AND 3. Material support in the last 30 days

	AND 4. Social support in the last 30 days. **OR** Women and men who died in the past 12 months, age 18–59 when they died, and who had been chronically ill for 3 months before death and whose household received the following support: 1. Medical support at least once a month during illness AND 2. Emotional support in the last 30 days (before the death) AND 3. Material support in the last 30 days (before the death) AND 4. Social support in the last 30 days (before the death).
Denominator:	All adults aged 18–59 who were ill for 3 or more months during the past 12 months, including those ill for 3 or more months before death.
How To Measure It:	The following methods are recommended: • A population-based household survey can be used in high-prevalence settings. As part of a household survey, household rosters can be used to identify all eligible chronically ill people aged 15–59. For each household with a chronically ill member, a series of questions is asked about the types and frequency of support received and primary source of the help. • A special study: the household survey tool may be used in low-prevalence settings or targeted populations with similar but adapted methods sampling networks of people living with HIV/AIDS and/or recipients of services from care and support programs. Data should be analyzed and reported by gender and age categories when sample size allows (15–24, 25–39, and 40–59 years). Each component on type of support will also be reported on separately, i.e., percentage whose households received medical support, percentage whose households received emotional support, and so on.
Interpretation/ Strengths and Weaknesses:	Household-based samples of chronically ill people are not nationally representative of all chronically ill people because they exclude those who are hospitalized, institutionalized, or homeless. As a result, the proportion of the population "missed" varies. Other targeted sampling among groups such as facility clients, home-based care recipients, or PLWHA network members (as discussed above in "How To Measure It") should be done to address this problem.
Reference(s):	Adapted from UNAIDS Care & Support Guide (2004-Reference #8) Indicator CS9

Core: Care, Treatment, and/or Support 5

Percentage of people still alive at 6, 12, and 24 months after initiation of treatment

Rationale/What It Measures:	One of the goals of any ART program should be to increase survival among infected individuals. This indicator measures the degree to which treatment can prolong a person's life by assessing how many individuals survived after 6, 12, and 24 months of receiving treatment.
Definition:	Percentage of people still alive at 6, 12, and 24 months after initiation of treatment
Measurement Tool:	HMIS +cohort studies
Numerator:	Number of individuals still alive after initiating treatment after 6, 12, and 24 months
Denominator:	Number of individuals initiating treatment at the same time
How To Measure It:	Information on survival beyond specific points in time can be collected in patient registers. This indicator will require that a cohort of patients be followed up. Data should be analyzed by sex and age.
Interpretation/ Strengths and Weaknesses:	The strengths of this indicator lay in the ease of data collection, as any ART program should monitor patients on treatment and determine the number of individuals who survive beyond specific periods in time. For some patients, follow-up information may not be available as a result of migration, complete treatment failure, or even death. Programs may deal with this loss by including only those individuals for whom they have full information in the numerator and denominator. Interpretation of trends in this indicator is enhanced when information on health status at treatment initiation is also available. Health outcomes, including survival rate, at the beginning of programs will be poor because this first cohort will be the sickest. Over time, this effect will level out. Clinical staging or mean CD4 count is helpful information for interpretation of trends.
Reference(s):	WHO 3x5 (2004-Reference #9) Core Indicator 10

Proportion of all deaths attributable to HIV/AIDS

Rationale/What It Measures:	Measuring impact of scaled-up ART programs will not be accomplished simply using ANC sentinel surveillance data. These data will be insufficient to model the estimated number of persons with AIDS and the number of deaths due to AIDS, or to assess trends. Additional information is urgently needed to improve these estimates. Sample registration approaches offer an important near-term solution to the current state of ignorance (particularly on the levels, causes, and trends of adult health mortality) in countries where good coverage of routine vital registration with reliable cause of death attribution is still years, if not decades, away. Although, by definition, they do not have the coverage of routine systems or censuses, continuous sample registration systems can also complement sources such as decennial censuses, which provide no way of directly monitoring progress in many key indicators at regional or national levels during inter-censal periods.
Definition:	Proportion of all deaths attributable to HIV/AIDS
Measurement Tool:	National mortality statistics or sample vital registration through verbal autopsy (SAVVY)
Numerator:	Incident death attributable to HIV/AIDS in the resident population aged 18-59
Denominator:	All deaths in the resident population aged 18-59
How To Measure It:	Sample vital registration through verbal autopsy consists of a set of large samples selected to be nationally representative and/or to represent sentinel areas or populations in which sample vital registration and mortality surveillance are carried out over a ten-year cycle. The 'backbone' of SAVVY is routine demographic surveillance, continuous (e.g., every 6 months in urban areas) mortality surveillance using verbal autopsy techniques, and the application of a validated income poverty measurement tool. During annual census update rounds, nested sample household surveys are conducted on health service coverage, poverty monitoring, or morbidity. These 'modules,' which can be harmonized with the DHS or other national household surveys, can generate enormous amounts of information about service coverage, population health status, food security, or any other topic amenable to household data collection and survey methods. Sampling varies per country, but is a combination of urban/rural. Verbal autopsy methods comprise of an interview by trained personnel with relatives of deceased individuals within a specified time period after death, using standard field instruments and interviewing techniques, with the objective of obtaining the best available information on the symptoms and events during the illness preceding death. Following the interview, the data collected are reviewed, usually by a physician panel, which assimilates all the information and attributes

	a probable underlying cause of death.
Interpretation/ Strengths and Weaknesses:	For populations in which a majority of deaths occur outside of health facilities, verbal autopsy techniques are possibly the only systematic way of ascertaining probable cause of death and developing an accurate picture of the cause structure of mortality within that population. The Emergency Plan support for lifelong antiretroviral therapy and other services is being mounted in countries where health systems have been geared to treat acute and episodic illnesses in clinical settings—not to deliver and monitor long-term care and management of chronic conditions that will entail significant outreach and follow-up components. There are no 'off the shelf' models for delivering this care in such resource-constrained settings, or for monitoring its successes and failures. Cross-sectional surveys and facility-based systems are unlikely to be able to meet these demands alone. Sample vital registration with verbal autopsy is an adaptable and cost-effective standard for the continuous monitoring of population health (morbidity and mortality) and poverty. SAVVY is an information system based largely on over a decade of experience from Tanzania in developing and packaging the methods, proving their sustainability and cost-effectiveness. It also draws upon the well-established systems of sample registration in India and China.
Reference(s):	WHO, MEASURE Evaluation, and the International Programs Center (IPC) of the U.S. Census Bureau (2003-Reference #15). *Improving Systems for Monitoring and Measurement of Vital Events: An issues paper prepared for the Health Metrics Network*.

Core: Orphans and Vulnerable Children 1

Percent of orphans and vulnerable children under 18 living in households whose households have received, free of user charges, basic external support in caring for the child

Rationale/What It Measures:	This indicator measures support coming from a source other than friends, family, or neighbors (unless they are working for a community-based group or organization) given free of user charges to households with orphans and vulnerable children.
Definition:	Percent of orphans and vulnerable children under 18 living in a household whose households have received, free of user charges, basic external support in caring for the child
Measurement Tool:	Population-based survey such as DHS/AIS, MICS
Numerator:	Number of orphans and vulnerable children residing in households that received: a. health care support within the past 12 months; b. emotional support within the past 3 months; c. school-related assistance within the past 12 months; d. other social support, including material support, within the past 3 months; and e. all four types of support. Orphan (at least one dead parent) AND/OR vulnerable child (at least one chronically ill parent) whose household has received: 1. Medical support within the last 12 months; AND 2. Emotional/psychological support within the last 3 months AND 3. Material support within the last 3 months AND 4. Social support within the last 3 months AND 5. School-related assistance within the past 12 months.
Denominator:	ORPHANS: All children under 18 who have at least one dead parent (mother or father) AND VULNERABLE CHILDREN: All children under 18 who have a chronically ill parent (mother or father) defined as a parent who has been very sick for 3 or more months during the last 12 months, regardless of whether or not the ill parent lives in the household.

How To Measure It:	As part of a household survey, household rosters can be used to identify all eligible orphans and vulnerable children (under 18 years of age). For each household with orphans and vulnerable children, a series of questions is asked about the types and frequency of support received and the primary source of the help. The following methods are recommended: • A population-based household survey can be used in high-prevalence settings. As part of a household survey, household rosters can be used to identify all eligible chronically ill people 15–59 years old. For each household with a chronically ill member, a series of questions is asked about the types and frequency of support received and primary source of the help. • A special study: the household survey tool may be used in low-prevalence settings or targeted populations with similar but adapted methods sampling networks of people living with HIV/AIDS and/or recipients of services from care and support programs. Data should be analyzed and reported by age (0–5, 6–9, 10–14, and 15–17 years) and gender. Depending on the epidemiological situation and available resources, program managers may decide to aggregate age data into larger ranges (0–9, 10–14, and 15–17 years). Each component of type of support will also be reported on separately, i.e., percentage whose households received medical support, percentage whose households received emotional support, and so on.
Interpretation/ Strengths and Weaknesses:	The greatest limitation of this indicator is its inability to distinguish whether needs are being met. Not all households caring for orphans need help. The needs of households with multiple orphans may be greater than those with a single orphan, but this will not be captured in this measure. Unfortunately, needs assessment is beyond the scope of a regular population-based survey. Experience shows that response rates are very high when people are asked whether they need extra support, though more qualitative work distinguishes large differences in actual coping capacity of households that say they would like extra help. Although it gives a picture of overall coverage or orphan support programs, this indicator does not measure the extent to which support is reaching the neediest. Orphans are a very mobile population. Those most in need of care may be in child-headed households that do not even qualify for inclusion in a household survey. Street children and others who live outside regular households will also be missed; in some urban areas these children may make up a substantial fraction of orphans in greatest need of care. By using a measure based on children currently in care, the measure will also miss households who have recently passed on orphans to other homes (perhaps precisely because they received no help with care). Using a measure based on orphan residence in households in the previous 12 months would, however, lead to problems of double counting and other measurement difficulties.

Reference(s):	Adapted from UNAIDS (2000-Reference #7) Care and Support Indicator 5; UNAIDS Care & Support Guide (2004-Reference #8) Indicator 10; and GFTAM Toolkit (2004-Reference #12) Care and Support Indicator 1

Percent of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines

Rationale/What It Measures:	Laboratory assessment of HIV status and need for treatment is essential to ensure the appropriate and effective use of antiretroviral combination therapy. Monitoring the ability of laboratories to carry out minimal, as well as more advanced, testing requirements is therefore essential. The purpose of this indicator is therefore to assess the availability of laboratories with the capacity to monitor the people receiving antiretroviral combination therapy according to international guidelines.
Definition:	Percentage of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines To scale up antiretroviral use in resource-constrained settings, WHO categorizes currently available testing into four levels of priority: 1. absolute minimum tests before starting antiretroviral combination therapy: HIV antibody test and hemoglobin or hematocrit level; 2. basic tests: white blood cell count and differential, serum alanine or aspartate aminotransferase level, serum creatinine, blood urea nitrogen, serum glucose and pregnancy test; 3. desirable tests: bilirubin, amylase, serum lipid and CD4 count; and 4. optional tests: viral load. Designated laboratories refer to nationally identified laboratories for monitoring antiretroviral combination therapy.
Measurement Tool:	Special laboratory study
Numerator:	Number of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines Laboratories are classified into three levels as follows: • level 1: they meet the minimum testing requirements for testing categories 1 and 2 (above); • level 2: they meet the minimum testing requirements for testing categories 1, 2, and 3; and • level 3: they meet the minimum requirements for all four testing categories.
Denominator:	Total number of designated laboratories
How To Measure It:	Data will be obtained from a survey of designated laboratories. Data collection will entail observing the availability of functioning equipment and supplies to run the tests at each level.

Interpretation/ Strengths and Weaknesses:	Although this indicator attempts to assess the quality of laboratories by assessing the existence of specific equipment, it does not address human resource needs. Specifically, the presence of a trained laboratory technician available on site to perform the tests required at each level is not currently included.
Reference(s):	UNAIDS Care & Support Guide (2004-Reference #8) Indicator CS8

Percent of health facilities with record-keeping systems for monitoring HIV/AIDS care and support

Rationale/What It Measures:	This indicator is designed to measure the capacity of health facilities to collect data on care and support services and to compile these data.
Definition:	Percentage of health facilities with record-keeping systems for monitoring HIV/AIDS care and support
Measurement Tool:	Health facility survey such as the Service Provision Assessment
Numerator:	Number of health facilities maintaining adequate records on the services provided
Denominator:	Total number of health facilities surveyed
How To Measure It:	The following methods are recommended: • health facility surveys that examine records on HIV/AIDS care and support services; and • qualitative interviews with people responsible, including interviews with officers of the health management information system. Facilities will be checked for: 1. records indicating clients receiving pre- and post-test counseling, as well as test results; 2. records indicating clients treated for HIV/AIDS-related illness; 3. evidence that reports for HIV/AIDS services are submitted on a routine basis The data should be disaggregated by department and service.
Interpretation/ Strengths and Weaknesses:	Patient record systems are diverse within facilities, making comparison across sites difficult. There is also no international (or national) standard for data reporting that can be used to assess whether the record-keeping system is adequate.
Reference(s):	UNAIDS Care & Support Guide (2004-Reference #8) Indicator CS-A2

Core: Other: Policy and Systems Strengthening (Capacity Building) 1

AIDS Program Effort Index

Rationale/What It Measures:	The AIDS Program Effort Index is a composite index designed to measure political commitment and program effort in the areas of HIV prevention and care. It tries to capture many of the inputs and outputs of a national HIV/AIDS program. The score is made up of 10 main components of an effective national response: political support, policy formulation, organizational structure, program resources, evaluation and research, legal and regulatory aspects, human rights, prevention programs, care programs and service availability.
Definition:	The average score given to a national program by a defined group of knowledgeable individuals asked about progress in over 90 individual areas of programming, grouped into 10 major components
Measurement Tool:	The AIDS Program Effort Index (API) questionnaire and protocol (Special study)
Numerator:	N/A
Denominator:	N/A
How To Measure It:	The API uses key informants from a designated mix of institutions to give opinions about central areas of commitment and programming, compiling an index out of scores given in various areas. The score, which is calculated as a percentage with zero indicating no program effort and 100 indicating maximum effort, may be converted into a grade to minimize informant variation. Suggested grades range from very weak and weak through moderate and strong to very strong, depending on the range in which the numerical scores fall.
Interpretation/ Strengths and Weaknesses:	The major concerns surrounding the API are its subjectivity and its reliability. The outcome depends entirely on the choice of informants, and informants will likely change from year to year. Since the indicator is still under development, the choice of informants has not yet been standardized. Questions have also been raised about the utility of a single composite score, in which improvements in some areas may be masked by deterioration in other areas. For diagnostic as well as monitoring purposes, it may be more useful simply to publish the indices separately by category. The separate category scores may stand alone as indicators, although for several areas of program effort, this document proposes alternatives which are based on measured parameters rather than expert opinion and may therefore be more useful in tracking trends over time. One area in which the API process may yield a particularly useful indicator is in the area of policy formulation (Section 20 of the API protocol).
Reference(s):	UNAIDS (2000-Reference #7) Policy Indicator 1

Core: Other: Policy and Systems Strengthening (Capacity Building) 2

Percent of the general population with accepting attitudes toward PLWHA

Rationale/What It Measures:	This is an indicator based on answers to a series of hypothetical questions about men and women with HIV. It reflects what people are prepared to say they feel or would do when confronted with various situations involving people living with HIV.
Definition:	Percent of women and men aged 15–49 expressing accepting attitudes toward people with HIV, of all women and men aged 15–49 surveyed who have heard of HIV
Measurement Tool:	Population-based survey such as the UNAIDS general population survey; DHS/AIS; BSS (adult +youth), RHS
Numerator:	Number of women and men who report an accepting attitude on all four of these questions
Denominator:	Number of all women and men aged 15–49 surveyed who have heard of HIV
How To Measure It:	Respondents in a general population survey who have heard of HIV are asked a series of questions about people with HIV, as follows: • If a member of your family became sick with the AIDS virus, would you be willing to care for him or her in your household? • If you knew that a shopkeeper or food seller had the AIDS virus, would you buy fresh vegetables from him/her? • If a female teacher has the AIDS virus but is not sick, should she be allowed to continue teaching in school? • If a member of your family became infected with the AIDS virus, would you want it to remain a secret? The indicator should be reported separately for men and women.
Interpretation/ Strengths and Weaknesses:	Methodologically, this is a relatively easy way to construct an indicator of attitudes toward people with HIV. A low score on the indicator is a fairly sound indication of high levels of stigma, and for that reason alone it is worth measuring. There are, however, difficulties in interpreting indicators based on hypothetical questions, and a high score on the indicator is harder to understand. It could mean there is little real stigma attached to HIV. Or it could mean that people know they should not discriminate, and therefore report accepting attitudes. This may not change their behavior, which may continue to be discriminatory toward people with HIV. Changes in the indicator could therefore reflect a reduction in stigma or simply a growing awareness that it is not nice to own up to one's prejudices. That in itself may, however, constitute the first step in program success. High scores may also reflect the respondent's limited personal experience with someone who is HIV-infected. The proposed indicator is similar to an earlier measure developed by WHO, but questions have been changed following field testing to better reflect situations in which people with HIV actually suffer from stigma. Field tests revealed that responses

	are greatly affected by the exact wording of the indicator. When the gender of the teacher was not specified, for example, one country registered very high levels of "discriminatory" attitudes on that question, for example. Further investigation showed that the negative attitudes were related to recent news reports of male teachers infecting female pupils with HIV.
Reference(s):	Adapted from UNAIDS (2000-Reference #7) Stigma and Discrimination Indicator 1

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ACRONYMS AND ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
AIS	AIDS Indicator Survey
ANC	antenatal care
API	AIDS Program Effort Index
ART	antiretroviral therapy
ARV	antiretroviral (drug)
BCC	behavior change communication
BSS	behavioral surveillance survey
BUCEN	United States Bureau of the Census
CS, C&S	care and support; UNAIDS document: *National AIDS Programmes: A Guide to Monitoring and Evaluating HIV/AIDS Care and Support* (see References)
CDC	Centers for Disease Control and Prevention
COP	Country Operational Plan
CRIS+	Country Reporting Information System Plus
CSW	commercial sex worker
DHS	Demographic and Health Survey
DOD	United States Department of Defense
DSS	Demographic Surveillance System
EPP	Estimate and Projection Package
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria; *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, and Malaria* (see references)
HCD	human capacity development
HHS	Health and Human Services
HIV	human immunodeficiency virus
HMIS	health management information system(s)
HMN	Health Metrics Network (WHO)
HRSA	Health Resources and Services Administration
IDU	injecting drug user
IEC	information, education, communication
IPC	International Programs Center (BUCEN)

IWG	Implementation Working Group (USAID HIV/AIDS Coordination)
M&E	monitoring and evaluation
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MIS	management information system(s)
MOS	Medical Outcome Survey
MSM	men who have sex with men
NAC	National AIDS Councils
OI	opportunistic infection
OVC	orphans and vulnerable children
PDB	Programmatic Database (The Synergy Project)
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
PMTCT+	prevention of mother-to-child transmission plus
RARG	*WHO Injection Practices: Rapid Assessment and Response Guide* (see references)
RHS	Reproductive Health Survey
S/GAC	United States Department of State/ Office of the Global AIDS Coordinator
SAVVY	Sample Vital Registration through Verbal Autopsy
SI	Strategic Information
SIGN	Safe Injection Global Network
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations AIDS Programme; UNAIDS document: *National AIDS Programmes: A Guide to Monitoring and Evaluation*. (see references)
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
USG	United States Government
VA	verbal autopsy
VCT	voluntary counseling and testing
WHO	World Health Organization
YPG	UNAIDS document: *Guide to Monitoring and Evaluating National HIV/AIDS Programmes for Young People* (see References)